IRATA SAFETY BULLETIN
SB33 Fall From Height
During Operations

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Issue No.	SB33 Fall From Height During Operations
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1. The Incident

At around 10h30 on 11 October 2014 a Rope Access Technician Level 1 (IP1) fell from a building roof level to the 2nd floor level of the seven-storey building. All team members and eyewitnesses who were on the scene of the incident were interviewed.

The incident took place after the team had completed their first section of work, during the time that the ropes were being shifted to the next section, but prior to the completion of the rigging. The Level 3 Supervisor (L3S) was responsible for the rigging and was at the ground level on the north elevation busy with rigging and being assisted by a Ground Support Technician (GST1). GST1 was responsible for establishing the exclusion zone and for radio communication with Rope Access Technician Level 2 (RATL2) who was team leader on the rooftop and all communication was done in their mother tongue, to avoid confusion. RATL2 was responsible for communication on the roof and for all rigging assistance and safety measures on location.

At approximately 10h25, RATL2 received information from L3S that the rigging of three sets out of five (1, 2 & 5) are complete and that the team should get ready to start their work on the south elevation. Once the information was received, RATL2 instructed two technicians to start attaching to their ropes in location 1 and 2. At this point one of these technicians requested additional rope protectors from RATL2, who then left to another part of the roof to collect the items.

During the absence of RATL2 two technicians, IP1 and Rope Access Technician 1 (RAT1) proceeded to attach themselves to their individual sets of rope (3 & 4) and positioning themselves on the parapet wall without receiving instruction to do so from the team leader or supervisor. At approximately 10h30, IP1 proceeded to lower himself off the parapet wall and onto his working ropes, but as he let go of the parapet wall committing his entire weight to the ropes the ropes started slipping. IP1 fell two floors where he hit a ledge of approximately 1 meter wide. He rolled off the ledge and proceeded falling the further three floors to the landscaped area on level 2 of the building.

At this point security responded to the sound of the impact and rushed to assist IP1. They released him from his ropes and removed his harness. IP1 was then assisted to go inside the building where he was made comfortable inside the security room on the floor and the security phoned the ambulance service. At the same time on the roof RAT1 informed RATL2 of the incident and RATL2 immediately let L3S know by radio. All technicians went to level 2 to assist IP1, but were prevented access to him by building security until the ambulance arrived and took him to hospital at 11h20.

Detail of injury noted as bruises, bone fracture and ligament damage.

Parts of injury damage noted as left little finger, right foot and right hip.
Cause of accident noted as human error/procedure not correct/carelessness.
Injury agent noted as concrete slab and loose stone landscaped area.

2. Incident Analysis

Corrective action request taken to prevent re-occurrence or eliminate hazard:
An immediate investigation was carried out by the QHSE Manager of the Operating Member Company (OMC) assisted by OMC Safety Officer and in collaboration with the building Associate Director Public Safety, Building Facility Project Manager, Site HSE Manager and site security. All site personnel were interviewed on site excluding L3S who was taken by the police and interviewed at a later stage after his release, on the same day. IP1 was interviewed in the hospital while awaiting the results of his CT scans and x-rays.

A close door emergency meeting was called by OMC Head of Division and attended by division management, operations management, assistant managers involved and site management and supervision. During the meeting all documentation was examined, all procedures where discussed and analysed and corrective actions where determined.

Root cause:

- Human error
- Poor communication

3. Control Measures Implemented

When rigging activities are carried out that are not in line of site of the technician from where he will access the system then no one will be allowed to transfer onto the ropes until the Level 3 supervisor has checked the rigging and is back on the roof or access level to give personal approval for technicians to access the system.

When rigging activities are carried out that are not in the line of site of the technician from where he will access the system then all access ropes are to be positioned on the roof or access level and not lowered over the building edge until the Level 3 Supervisor has checked the rigging and returned to the access level and gives all technicians the approval to access the ropes.

A green tag system will be implemented where the Level 3 supervisor responsible for the rigging will have to do a green tag on a daily basis for each set of ropes. The tag will contain the following information – supervisor name, date and signature.

Immediate meetings were held with all OMC Supervisors explaining the incident and discussing root cause with preventative measures.

Scheduled meetings are being held with all OMC personnel over the course of the next week to discuss the incident, root cause and the preventative measures emphasising the fact that safety is everyone's personal responsibility first.

Method statement templates are amended to provide a place for signatures by assistant managers and supervisors (every supervisor who gets to the site – even as a replacement for another need to sign a new method statement document with the site assistant manager) of OMC to assure procedures are explained, understood and handed over.

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